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IN THE UNITED STATES PATENT AND TRADEMARK OFFICE

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In re Application of: Efendic et al.

Serial No.: 09/754,723

Group Art Unit: 1614

Filed: January 4, 2001

Examiner: P. Duffy

Confirmation No.: 3358

For: Use Of A Peptide

**PETITION TO CORRECT INVENTORSHIP UNDER 37 CFR 1.48(b)**

Assistant Commissioner for Patents  
Washington, DC 20231

Sir:

Applicants hereby petition to change the inventorship in the above-captioned application to delete inventors Suad Efendic and Mark Gutniak from the above-captioned patent application.

The correct inventors were named in the application when filed. However, the prosecution of the application has resulted in the amendment and cancellation of claims so that less than all of the originally named inventors are the actual inventors of the invention being claimed in the application.


Applicants therefore have deleted Suad Efendic and Mark Gutniak as inventors.

Applicants respectfully request the grant of this petition.

Please charge the fee, required under 37 C.F.R. §1.17(i) estimated to be \$130.00, to Novo Nordisk Pharmaceuticals, Inc., Deposit Account No. 14-1447. A duplicate of this sheet is enclosed.

Respectfully submitted,

Date: May 5, 2003

  
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## Effect of Truncated Glucagon-Like Peptide-1 [Proglucagon-(78-107) amide] on Endocrine Secretion from Pig Pancreas, Antrum, and Nonantral Stomach

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**ABSTRACT.** We studied the effect of truncated glucagon-like peptide-1 [naturally occurring GLP-1; proglucagon-(78-107) amide], a potent insulinotropic peptide from the pig ileum, on endocrine and exocrine secretion of potential gastrointestinal target organs using isolated perfused preparations of the porcine pancreas, antrum, and nonantral part of the stomach. Truncated GLP-1 significantly increased somatostatin secretion from the pancreas at  $10^{-10}$  mol/liter and more than doubled the secretion at  $10^{-9}$  mol/liter, but had no effect on either somatostatin or gastrin secretion from the antrum or on somatostatin secretion from the nonantral stomach in concentrations up to  $10^{-9}$  mol/

liter. Insulin secretion from the pancreas (with 7 mmol/liter glucose in the perfusate) increased 2-fold with truncated GLP-1 at  $10^{-10}$  mol/liter and almost 5-fold at  $10^{-9}$  mol/liter. Pancreatic glucagon secretion was inhibited by 50% at  $10^{-10}$  mol/liter and by 70-80% at  $10^{-9}$  mol/liter. Full-length GLP-1 [proglucagon-(72-107)] and GLP-2 [proglucagon-(126-169)] had no effect on hormone secretion from any of the perfused organs. It is concluded that truncated GLP-1 may participate in an enteroinular control of pancreatic endocrine secretion. (*Endocrinology* 123: 2009-2013, 1988)

**M**AMMALIAN proglucagon has been shown to contain two glucagon-like sequences [glucagon-like peptide-1 (GLP-1) and glucagon-like peptide-2 (GLP-2)] in addition to glucagon itself (1). We recently isolated from pig small intestine and partially sequenced a naturally occurring GLP-1 (2). This peptide was found to correspond to proglucagon-(78-107) and thus represents a truncated form of GLP-1 [which corresponds to proglucagon-(72-107 or 108)] (1). Natural GLP-1 is highly homologous to glucagon, with 14 identically positioned amino acids. In preliminary studies, truncated GLP-1 had strong insulinotropic effects on perfused preparations of pig and rat pancreas (2, 3).

Many of the members of the glucagon family of peptides have been shown to stimulate both insulin and somatostatin secretion from the pancreas and to increase somatostatin release from the stomach (4). We, therefore, studied the effects of truncated GLP-1 as well as full-length GLP-1 and GLP-2 on the endocrine secretions of the pig pancreas and stomach using three isolated tissue preparations perfused *in vitro*: the pancreas, the antrum plus pancreas, and the nonantral (antrectomized) stomach.

### Materials and Methods

Twenty pigs of the strain LYY, weighing 12-18 kg, served as donors. Anaesthesia was induced with 2.5% halothane and maintained with chloralose (no. 2420, Merck, Darmstadt, West Germany; 100 mg/kg) after intubation and artificial ventilation. Details on the preparation of the pancreas and the antrum for perfusion have been described (5, 6). The perfused antrum consists of the antrum plus the pancreas, because these structures to a great extent share the same vascular supply. Effluent derived solely from the antrum was obtained by catheterization of the right gastroepiploic vein (6), while the effluent collected simultaneously from a catheter placed in the portal vein is derived from the antrum as well as the pancreas.

Isolation and perfusion of nonantral porcine stomach were performed as described previously (7). In short, the stomach was isolated together with the spleen; in the pig it is impossible to separate the vascular supply of the two organs. The antrum was excised, leaving the gastroepiploic vascular arcades intact. The stomach was closed by sutures in two layers. The remaining stomach (together with the spleen) was placed in a thermostated bath containing Ringer solution and perfused through the coeliac trunk. A draining tube was inserted into the stomach lumen, which was perfused at a rate of 8 ml/min with preheated saline. The acid secretion of the preparation was determined by titration of the luminal effluent with 0.1 mol/liter sodium bicarbonate (7). The medium for vascular perfusion was a Krebs-Ringer bicarbonate solution supplemented with washed bovine erythrocytes (20%, vol/vol), 1 g/liter human serum albumin (Behringwerke, Marburg, West Germany), 5% dextran

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T-70 (Pharmacia, Uppsala, Sweden), 7 mmol/liter glucose, a total of 5 mmol/liter of a mixture of amino acids (Amodex Asa, Pharmacia), aprotinin (100,000 kallikrein inhibitor units/liter, Trasylol, Bayer, Leberkussen, West Germany), and indomethacin (5 mg/liter; Confortid, Dumex, Copenhagen, Denmark) to prevent the formation of prostaglandins from the red blood cells. (The same perfusion medium, but containing only 15% red blood cells, was used for the pancreas and antrum perfusions.) The perfusion medium was equilibrated with a mixture of 95% O<sub>2</sub> and 5% CO<sub>2</sub>. The perfusion flow was kept constant at 0.3 ml/min·g. The flow of effluent from the right gastroepiploic vein varied between 2–5 ml/min. The portal venous outflow varied between 24 and 42 ml/min. Oxygen consumption, determined as described previously (7), averaged 5.7  $\mu$ l O<sub>2</sub>/min·g tissue. The venous effluent was collected every minute, chilled on ice, centrifuged within 20 min, and stored at -20 C until analysis for somatostatin, glucagon, gastrin, and insulin.

Synthetic truncated GLP-1 [proglucagon-(78–107) amide] was obtained from Peninsula Laboratories (Merseyside, England) by custom synthesis (lot no. 008802; peptide purity by amino acid analysis, 72%). Before it was used in physiological studies the peptide was purified to homogeneity by isocratic reverse phase HPLC on an 8  $\times$  250-mm Nucleosil C-18 column, employing LKB pumps and detectors (LKB, Bromma, Sweden). Gas phase sequence analysis of the synthetic peptide confirmed that the peptide was proglucagon-(78–107) amide (2). Synthetic full-length GLP-1 [proglucagon-(72–107) amide] and GLP-2 [proglucagon-(126–159)] were obtained from Peninsula Laboratories (Belmont, CA; catalog no. 7166 and 7167); synthetic vasoactive intestinal polypeptide (VIP) and gastrin-releasing peptide (GRP) were also from Peninsula (code no. 7161 and 7188). The peptides were dissolved in perfusate, previously equilibrated with N<sub>2</sub> to prevent oxidation, and infused into the arterial line, resulting in final perfusate concentrations between 10<sup>-11</sup>–10<sup>-8</sup> mol/liter. Carbachol was obtained from Danmarks Apotekerforenings Kontrollaboratorium A/S (Copenhagen, Denmark).

Somatostatin-like immunoreactivity was measured using antiserum 1758, directed against the 5–10 sequence, synthetic somatostatin-(1–14) (Ferring, Malmö, Sweden) and [<sup>125</sup>I]Tyr-somatostatin (Novo Research Center, Bagsværd, Denmark), as described previously (8). This assay measures with equal efficiency all molecular forms of somatostatin (9). Gastrin-like immunoreactivity was measured using antiserum 2604, directed against the C-terminus of gastrin-17, synthetic gastrin, and [<sup>125</sup>I]gastrin, as described previously (10). Insulin and glucagon concentrations were measured by RIAs, as described previously (5). For all RIAs the sensitivity and experimental detection limit were below 2 pmol/liter. None of the assays showed cross-reactions with any known pancreatic or gastric peptide apart from those that contain the antigenic determinants against which the antisera were raised (5, 8–10). Specifically, the somatostatin antiserum did not bind calcitonin gene-related peptide (our unpublished studies), and the glucagon antisera did not cross-react with any of the GLPs derived from the C-terminal part of proglucagon (11). For statistical evaluation of results, average hormone outputs obtained during the 10-min

stimulation periods were compared with the average basal outputs in the preceding 5-min period, using the *t* test for paired data. For evaluation of the effects of time the Friedman analysis of variance with multiple comparisons was used where applicable (12).

## Results

The results of this study are shown in Figs. 1–4, where the mean hormone outputs ( $\pm$ SEM) from the organs are plotted against time. We found that truncated GLP-1 significantly increased somatostatin output from the pancreas in a dose-dependent manner, when measured in both venous effluent from the completely isolated pancreas (Fig. 1) and effluent from the portal vein (as opposed to the right gastroepiploic vein) from the preparation that consisted of the pancreas plus the antrum (Fig. 2A). The average somatostatin output measured in the portal vein in six perfusion experiments increased from 16.6  $\pm$  0.2 to 20.3  $\pm$  0.5 pmol/min (*P* < 0.001) at a concentration of truncated GLP-1 of 10<sup>-10</sup> mol/liter and from 15.7  $\pm$  0.4 to an average output of 30.1  $\pm$  1.2 pmol/

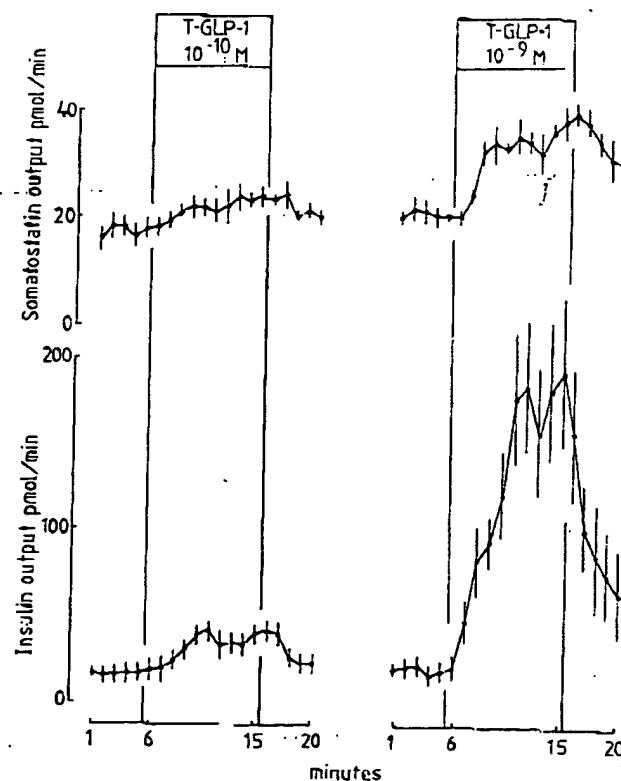


FIG. 1. Effect of truncated GLP-1 (T-GLP-1) at 10<sup>-10</sup> (left) and 10<sup>-9</sup> mol/liter (right) on somatostatin secretion (top panel) and insulin secretion (bottom panel) from the isolated perfused pancreas (*n* = 3). Hormone outputs (picomoles per min; mean  $\pm$  SEM) are plotted against time (minutes). The average hormone outputs during infusion of truncated GLP-1 at both 10<sup>-10</sup> and 10<sup>-9</sup> mol/liter increased significantly above the mean baseline output (*P* < 0.05).

## EFFECTS OF TRUNCATED GLP-1

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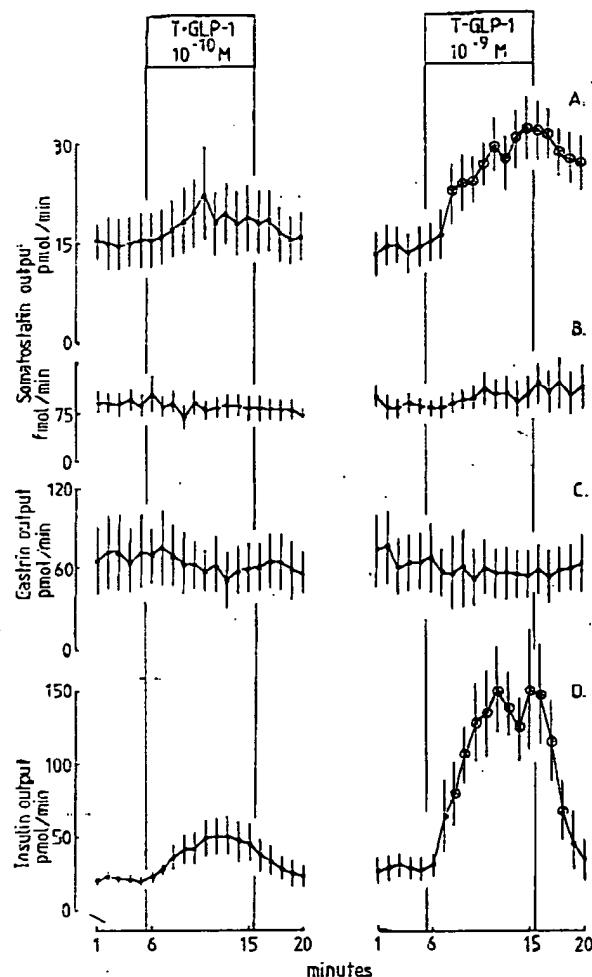


FIG. 2. Effects of truncated GLP-1 (T-GLP-1) at  $10^{-10}$  (left) and  $10^{-9}$  mol/liter (right) on somatostatin secretion, as measured in the portal vein (A) and the gastropiploic vein (B), on gastrin secretion (C), and on insulin secretion (D); measured in the portal vein effluent) from the isolated perfused antrum ( $n = 6$ ). Hormone outputs (picomoles per min or femtomoles per min; mean  $\pm$  SEM) are plotted against time (minutes). The mean somatostatin and insulin outputs in portal vein (A and D, left) during infusion of truncated GLP-1 at  $10^{-10}$  mol/liter increased significantly above basal levels ( $P < 0.001$ ).  $\circ$ , Significant change from baseline hormone secretion in response to infusion of truncated GLP-1 at  $10^{-9}$  mol/liter (identified after analysis of variance).

min at  $10^{-9}$  mol/liter. Truncated GLP-1 at  $10^{-10}$  and  $10^{-9}$  mol/liter ( $n = 6$ ) had no effect on the gastrin or somatostatin output from the antrum (as determined in effluent from the right gastropiploic vein; Fig. 2, B and C). Neither were there any effects on antral somatostatin output in two experiments with truncated GLP-1 at  $10^{-8}$  mol/liter, although insulin and portal venous somatostatin outputs exceeded those obtained with GLP-1 at  $10^{-9}$  mol/liter. In the same six perfusion experiments, infusion of GRP to a final concentration of  $10^{-9}$  mol/liter for 10 min increased the average antral venous

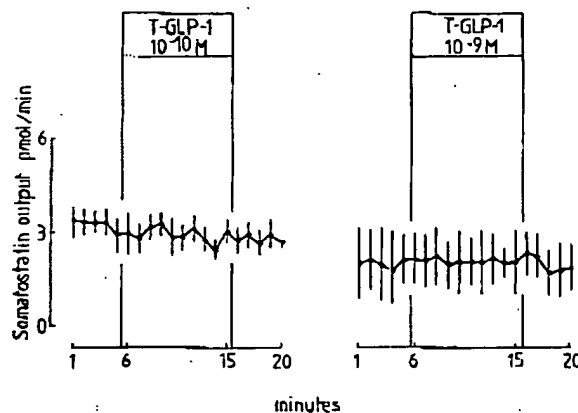


FIG. 3. Effect of truncated GLP-1 (T-GLP-1) at  $10^{-10}$  (left) and  $10^{-9}$  mol/liter (right) on somatostatin secretion from the isolated nonantral perfused stomach ( $n = 3$ ). Somatostatin output (picomoles per min; mean  $\pm$  SEM) is plotted against time (minutes).

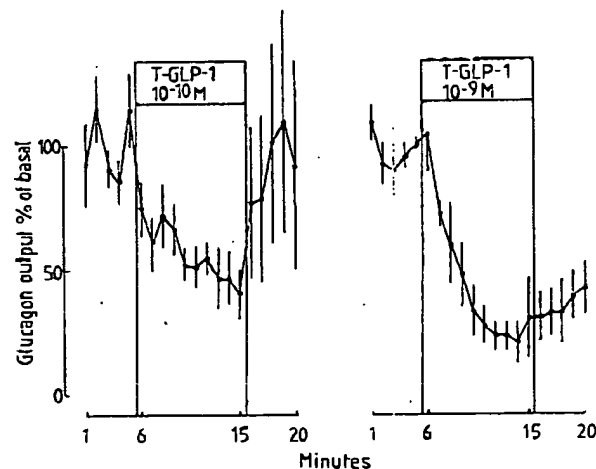


FIG. 4. Effect of truncated GLP-1 (T-GLP-1) at  $10^{-10}$  (left) and  $10^{-9}$  mol/liter (right) on glucagon secretion from the pancreas or pancreas plus antrum ( $n = 5$ ). Hormone output, expressed as a percentage of the mean prestimulatory hormone output  $\pm$  SEM, is plotted against time.

somatostatin output from  $0.125 \pm 0.02$  to  $0.23 \pm 0.02$  pmol/min ( $P < 0.001$ ). Truncated GLP-1 at  $10^{-10}$  mol/liter increased insulin secretion (as measured in the portal vein) from  $24 \pm 0.54$  to an average of  $51.2 \pm 2.9$  pmol/min ( $P < 0.001$ ); it increased insulin secretion from  $34.5 \pm 0.7$  to  $144 \pm 11$  pmol/min at  $10^{-9}$  mol/liter. In the pancreatic perfusions (Fig. 1) truncated GLP-1 at  $10^{-9}$  mol/liter increased insulin secretion more than 6-fold. In general, glucagon outputs from both preparations were low (as a consequence of the 7 mmol/liter glucose in the perfusate). Thus, a consistent glucagon output was measurable in only five perfused preparations (two completely isolated pancreas preparations and three preparations of pancreas plus antrum). The prestimulatory basal output averaged  $5.5 \pm 4.0$  pmol/min before  $10^{-10}$  mol/liter GLP-

1) and  $2.03 \pm 0.98$  pmol/liter (before  $10^{-9}$  mol/liter). The responses to truncated GLP-1 infusion are shown in Fig. 4 (presented as fractional changes from basal levels because of large differences in absolute levels). Truncated GLP-1 caused a highly significant inhibition of glucagon output to less than 50% at  $10^{-10}$  mol/liter and to as little as 20% of basal output at  $10^{-9}$  mol/liter.

As shown in Fig. 3, there was no effect of truncated GLP-1 on somatostatin secretion from the isolated antrectomized nonantral stomach. In these experiments an intraarterial infusion of VIP to a final perfusate concentration of  $10^{-9}$  mol/liter for 10 min increased somatostatin secretion from a basal value of  $1.08 \pm 0.5$  to an average value of  $3.29 \pm 1.1$  pmol/min ( $P < 0.001$ ). Hydrochloric acid secretion from the antrectomized stomach, which averaged  $0.037 \pm 0.012$  mmol/min in the present experiments remained unaffected by truncated GLP-1 regardless of dose, but increased to  $0.15 \pm 0.01$  mmol/liter in response to a 10-min infusion of carbachol at  $10^{-6}$  mol/liter.

In all four pancreas perfusions and five nonantral stomach perfusions full-length GLP-1 and GLP-2 in concentrations ranging from  $10^{-11}$ – $10^{-8}$  mol/liter were without effect on somatostatin secretion or any other measured parameter. At a concentration of  $10^{-11}$  mol/liter in the perfusate none of the GLPs caused significant changes in hormone output from any of the preparations (not shown).

### Discussion

Recent results from our own and other laboratories suggest that truncated GLP-1, a 30-amino acid fragment of proglucagon, which is produced and secreted by the lower intestinal mucosa (2, 3, 14), is an incretin that may participate in an entero-insular control of the endocrine pancreas and, thus, in the postprandial regulation of blood sugar. Somatostatin has also been suggested to play a role in maintaining blood sugar homeostasis (4, 14, 15). It was, therefore, natural to investigate the effect on somatostatin secretion from the pancreas and stomach of this new member of the glucagon-secretin family of peptides, many of which have been shown to enhance somatostatin secretion (16–20). We have previously found concentrations of immunoreactive GLP-1 in peripheral human venous plasma around 100 pmol/liter in the fasting state and increases in response to mixed meals up to 150 pmol/liter (11). In further studies (21) we found that the majority of the GLP-1 immunoreactivity in fasting plasma was due to a large mol wt molecule, presumably the large proglucagon fragment that is secreted from the pancreas synchronously with glucagon (21). After the meal, however, the majority of GLP-1 immunoreactivity in plasma corresponded in size to the intestinal form of

GLP-1 (presumably truncated GLP-1) (22). The physiologically relevant concentration interval of GLP-1 in plasma would, therefore, be expected to be  $10^{-11}$ – $10^{-9}$  mol/liter, which was the range investigated in this study. In a few instances we also studied the effects of higher concentrations so as not to overlook eventual pharmacological effects, but such concentrations would not be expected to occur under physiological circumstances.

In agreement with our preliminary studies (2) and recent studies of perfused rat pancreases (3), truncated GLP-1 very potently stimulated insulin release from the pancreas at slight hyperglycemia. In addition, it stimulated somatostatin secretion from the pancreas with almost the same potency. In striking contrast, there was no effect on somatostatin secretion from two preparations of the stomach, an organ believed to contribute significantly to the concentrations of somatostatin measured in peripheral venous blood (9, 23, 24). It is unlikely that the lack of effect on the stomach should reflect impaired responsiveness of these preparations, since, in agreement with previous experience (25), GRP strongly stimulated somatostatin secretion from the antrum, and VIP increased somatostatin secretion from the antrectomized stomach, as has been reported for rat stomach (18, 20). The lack of effect of truncated GLP-1 is, therefore, more likely to reflect differences in the regulation of the gastric and pancreatic somatostatin cells. That the pancreatic and gastric somatostatin cells are different is also illustrated by the fact that the common precursor, prosomatostatin, is processed differently in the two tissues. In the pancreas the predominating product is somatostatin-14, whereas in the stomach significant amounts of somatostatin-28 and other larger forms are produced (9, 26). The viability of the perfused antrectomized stomach is further attested by the preserved secretory responses of hydrochloric acid (and pepsin) (7) to carbachol stimulation; in this case, however, somatostatin secretion is strongly inhibited.

Truncated GLP-1 strongly inhibited pancreatic glucagon secretion. This interesting effect could be due to interaction of truncated GLP-1 with specific receptors associated with an inhibitory second messenger system in the glucagon cells. Specific receptors for truncated GLP-1 (but not full-length GLP-1) have recently been demonstrated on insulin-producing rat insulinoma cells in culture (27), but so far nobody has identified receptors for truncated GLP-1 on glucagon cells. Another possibility is a paracrine effect, exerted via the increased secretion of somatostatin in the pancreatic islets. Such increases have previously been reported to inhibit glucagon secretion by a local paracrine pathway (28).

Full-length GLP-1 [proglucagon-(72–107) amide] and GLP-2 [proglucagon-(126–159)] were without effect on the endocrine or exocrine secretion of the three perfused

## EFFECTS OF TRUNCATED GLP-1

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organ preparations. For GLP-1 this shows that the biological activity of the natural (truncated) GLP-1, as for glucagon, requires an intact N-terminus (29). If full-length GLP-1 exists in mammalian tissues (30), it is, therefore, likely to be inactive. As previously shown, the amino acid sequence of porcine GLP-2 differs at four positions from the human sequence; in addition, the porcine form lacks the C-terminal basic amino acid residue of synthetic human GLP-2 (31). Our inability to detect any effects of synthetic human GLP-2 may, therefore, simply reflect the fact that we studied a peptide which is inactive because of differences between species. Porcine GLP-2 is not available for experimental studies at present.

In summary, our data suggest that truncated GLP-1 may participate in the control of pancreatic insulin, somatostatin, and glucagon secretion. In addition, our data show that the pancreatic somatostatin-producing cells respond to different stimuli and, therefore, probably express other receptors than the gastric somatostatin cells.

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